

LIMITED PERMIT EXAMINATION APPLICATION**Please READ Instructions before completing this form.****Type or print legibly.**

Name—last		first	middle		Date of birth		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address (number, street)			City	State	ZIP code	Home telephone number ()		
Social security number		E-mail address		Fax number ()		Business telephone number ()		

NOTE: "All information on this application is releasable to the public. You may submit a P.O. box number rather than a home address if no other business address is available." California Public Records Act (PRA), Government Code, Sections 6250, et seq.

Check (✓) the category(ies) you wish to test for:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Chest | <input type="checkbox"/> Skull | <input type="checkbox"/> Dental Laboratory | <input type="checkbox"/> Dermatology |
| <input type="checkbox"/> Extremities | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Leg Podiatry | <input type="checkbox"/> X-ray Bone Densitometry |
| <input type="checkbox"/> Torso-Skeletal | <input type="checkbox"/> Genitourinary | | |

Have you ever applied for a California Limited Permit? ☐ No ☐ Yes If yes, permit number _____

Please provide previous name(s) used if applicable _____

Schedule me for examination in (check one) ☐ Northern California ☐ Southern California In the month of _____

OATH: I hereby attest that the submitted documents and information are true and accurate. I acknowledge that I can not administer or use X-rays on human beings in the categories allowed by my OJT or clinical authorization until I have been issued permit(s) by the Department of Health Services.

Signature of applicant	Date
------------------------	------

PRIVACY NOTIFICATION: This information is requested by the Department of Health Services, Radiologic Health Branch, and is needed to determine your eligibility for admission to the Limited Permit examination pursuant to Section 106995 of the Health and Safety Code. Unless otherwise noted, the information requested is mandatory. Failure to provide the information may result in denial of your application. The information may be provided to federal, state, or local agencies for law enforcement purposes. For information or access to your records, contact: Chief, Radiologic Health Branch—Certification, P.O. Box 942732, MS 178, Sacramento, CA 94234-7320. Telephone: (916) 445-0931.

Mail: ☐ Application
☐ Supporting Documents
☐ Fee

To: Department of Health Services
Radiologic Health Branch—Certification
P.O. Box 942833, MS 178
Sacramento, CA 94234-2833

For Express Delivery only:

Department of Health Services
Radiologic Health Branch—Certification
601 North Seventh Street, MS 178
Sacramento, CA 95814

FOR DEPARTMENT OF HEALTH SERVICES USE ONLY

Category					Reviewed By	Date	Disposition
<input type="checkbox"/> C	<input type="checkbox"/> E	<input type="checkbox"/> T-S	<input type="checkbox"/> S	<input type="checkbox"/> GI			<input type="checkbox"/> Deficiency
<input type="checkbox"/> GU	<input type="checkbox"/> DR	<input type="checkbox"/> LP	<input type="checkbox"/> D	<input type="checkbox"/> B			<input type="checkbox"/> Acceptable
<input type="checkbox"/> C	<input type="checkbox"/> E	<input type="checkbox"/> T-S	<input type="checkbox"/> S	<input type="checkbox"/> GI			<input type="checkbox"/> Deficiency
<input type="checkbox"/> GU	<input type="checkbox"/> DR	<input type="checkbox"/> LP	<input type="checkbox"/> D	<input type="checkbox"/> B			<input type="checkbox"/> Acceptable
<input type="checkbox"/> C	<input type="checkbox"/> E	<input type="checkbox"/> T-S	<input type="checkbox"/> S	<input type="checkbox"/> GI			<input type="checkbox"/> Deficiency
<input type="checkbox"/> GU	<input type="checkbox"/> DR	<input type="checkbox"/> LP	<input type="checkbox"/> D	<input type="checkbox"/> B			<input type="checkbox"/> Acceptable

Exam Code: T ____ H ____ M ____ X ____ V ____ O ____ Q ____ J ____ S ____ K ____ F ____

Exam Code: T ____ H ____ M ____ X ____ V ____ O ____ Q ____ J ____ S ____ K ____ F ____

Passed: ☐ C ☐ E ☐ T-S ☐ S ☐ GI ☐ GU ☐ DR ☐ LP ☐ D ☐ BPassed: ☐ C ☐ E ☐ T-S ☐ S ☐ GI ☐ GU ☐ DR ☐ LP ☐ D ☐ B

Study materials: <input type="checkbox"/> XT Radiography syllabus	Study material mailed	By
<input type="checkbox"/> C <input type="checkbox"/> E <input type="checkbox"/> T <input type="checkbox"/> S <input type="checkbox"/> GI <input type="checkbox"/> GU <input type="checkbox"/> DR <input type="checkbox"/> LP <input type="checkbox"/> D <input type="checkbox"/> F		

Permit RHP number	Issue/code date	Issued by	School code	180 + date	Exam date
-------------------	-----------------	-----------	-------------	------------	-----------

INSTRUCTIONS
For Completing Limited Permit Examination Application

1. A single application form may be submitted for no more than **three** permit categories.
2. You will be scheduled for an examination upon receipt of:
 - a. A completed application form.
 - b. An application fee of \$45.78 for each permit category for which you are applying. Make check or money order payable to the "Department of Health Services." Application fee is nonrefundable.
 - c. A nonrefundable examination fee of \$70 in the form of a cashier's check or money order payable to the ARRT. The examination fee applies to all limited permit categories except dental laboratory and dermatology. The money will be forwarded to the ARRT once your application is approved. **(Personal checks will not be accepted.)**
 - d. Three completed self-addressed mailing labels (enclosed).
 - e. A copy of your X-ray technology program completion document or transcript **OR** submit a letter signed by the on-the-job training (OJT) licensee, who was approved by the Radiologic Health Branch (RHB) to train you, verifying completion of your didactic and/or clinical training.
 - f. Proof of meeting clinical requirements. Minimum requirements are three months training in each category and the required number of clinical procedures for each category completed during training. Be sure all documents are signed and dated by the approved supervising licensee.
 - g. Original logs of clinical X-ray procedures performed for each of the permit categories for which you are applying. The logs must be signed and dated by the RHB approved supervisor and operator licensee.
 - h. Completed performance evaluation forms signed and dated by approved supervisor and operator licensee.
 - i. Completed film critique forms signed and dated by approved supervisor and operator licensee.
 - j. Completed repeat film assessment forms signed and dated by approved supervisor and operator licensee.
3. If your application is approved for any category except dental laboratory or dermatology, you will be assigned a 90-day window in which to schedule an examination. A list of Prometric Testing Centers and scheduling instructions will be sent to you from the ARRT testing coordinator.
4. If your application is approved for dental laboratory or dermatology, RHB will (a) schedule you an examination; and (b) send you the necessary examination information including the time, date, and location of examination. Examination information will be sent to you within 30 days. Once your application has been approved, you will be contacted to make arrangements for an examination date.
5. **RHB will notify you of examination results in writing and within 30 days following examination date. NOTE: No test results can be given over the telephone.**

CATEGORIES FOR WHICH LIMITED PERMITS MAY BE ISSUED

1. "Chest radiography" means radiography of the heart and lungs.
2. "Extremities radiography" means radiography of the upper extremities including shoulder girdle, and lower extremities, **excluding pelvis.**
3. "Torso-skeletal radiography" means radiography of the shoulder girdle, bony rib cage, sternum, vertebral column, pelvis, and hip joints.
4. "Skull radiography" means radiography of the bone and soft tissue of the skull and upper neck.
5. "Gastrointestinal radiography" means radiography of the esophagus, stomach, small and large intestine, and biliary tract.
6. "Genitourinary radiography" means kidneys, ureters, urinary bladder, urethra and internal and external genitalia.
7. "Dental Laboratory" means radiography of the intra-oral cavity, skull, and hand and wrist, for dental purposes.
8. "Leg/podiatric radiography" means radiography of the knee, tibia, fibula, ankle, and foot.
9. "Dermatology X-ray therapy radiography" means application of X-ray to human beings for the treatment of diseases and tumors of the skin.
10. "X-ray bone densitometry" means a radiologic examination of all or part of the skeleton utilizing X-rays from an X-ray source, which is mechanically ganged to a detector for scanning all or parts of the skeleton, under computer control.

Applicants may apply for any or all of the limited permit categories listed above. However, applicants may not submit requests for more than three categories on a single application form.

PLEASE NOTE THAT IT IS UNLAWFUL TO USE X-RAYS UNLESS YOU HAVE PROPER AUTHORIZATION FROM THE DEPARTMENT.

The Radiologic Health Branch (RHB) is responsible for ascertaining the qualifications of applicants for the X-ray technician limited permit (Health and Safety Code, Section 114870(e), and Title 17, California Code of Regulations, Section 30445).